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ABSTRACT

This paper presents a psychology professor's account of his experiences teaching a course on Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus (AIDS/HIV) to college students. The first section discusses how to introduce and market the course on campus, and anticipate students' and colleagues' questions about one's motivations for teaching the course, one's sexual preference, and one's expertise. The second part discusses how to deal with religion, values, and morality, by asserting the objective from the outset (to stop the spread of AIDS by whatever means possible), and how to deal with the likelihood that terminology used in the course will offend some students. Also discussed are the problems of teaching students from diverse cultures and value systems. The third section addresses how to comment on current events and new potential cures, and how to address students' questions and concerns. The remaining sections discuss: how to resolve conflict among sources of information; how to find an appropriate level of knowledge and sophistication; topical coverage; pedagogical devices; audiovisual materials; and experiential exercises. The concluding sections discuss the distribution of activities across class periods and the problem of AIDS burnout. (TE)

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Teaching About AIDS/HIV Disease To College Students

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In S. R. Heyman (Chair) Psychosocial Implications of AIDS: Teaching Classes in Undergraduate Psychology Programs. A symposium presented on August 13, 1990, at the 1990 meeting of the American Psychological Association, Boston, MA.

AN INITIAL QUERY TO THE AUDIENCE- How many of you already are teaching a course on AIDS/HIV disease? How many of you intend to do so in the next year? How many are from a campus which already has an active AIDS education program? How many are from what they define as a "high HIV prevalence" locale? Obviously, differences in your answers to the latter two questions will effect your approach and the reception which your course receives.

This paper is based on my experience of having now taught this course four times, with an enrollment varying from 16 to 58.

<u>Introducing the course on campus</u>: its resistance/acceptance will vary depending on the existing campus atmosphere concerning HIV disease/AIDS. [A note on terminlogy: AIDS is a technical term for specific end stage diseases which result from infection with the human immunodeficiency virus. HIV disease covers a broad spectrum, including AIDS proper. in this paper, I will use the terms interchangably.] You might make the course "relevant," or try to sell it, using the same basis that I use to motivate the students taking it: the many, wide ranging effects of HIV in the world and US today, for example, but not limited to, the health care and economic system. [Asking students about their own health care insurance can make them realize the implications of overload on the health care system and HIV's potential personal effects on them.] N.B.: This can also raise an objection of turf - the course belongs in biology, social work, economics, etc. Here you just must sell your own expertise at being able to teach the wide range of appropriate material <u>at the undergraduate level.</u> We are talking about introductory, basic knowledge, not a professional level course, and this should help to minimize turf conflicts. You can also ask departments to have their own "experts" guest lecture on the topic about

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which they have concerns (e.g., virology and immunology). Also, if a department says "we should be teaching this course," ask them "what do they have planned, and when will their course start?" The likely embarrassment at their having nothing planned should end that objection. You should also stress that the many issues involved in HIV are too pressing to wait for promised new course development, which may never come.

You will probably be asked about your own motivations for teaching this course, which can have implications for being labeled as gay or lesbian, if not HIV+, although (surprisingly) no one to date has personally asked me these questions in the context of my campus activities. Maybe it has just been presumed/known because of my previous community AIDS work. This is an issue you should be prepared to address while both proposing and teaching the class.

Additionally, once you are teaching the course you may be seen as a campus expert on the topic of AIDS, and be asked many veiled, personal questions such as "I have a friend who," and some not so veiled, when persons look to you as a resource or as a guide to resources. This can be a rewarding activity, but you should be prepared for it emotionally, time wise, and information wise; for example, you must know your local AIDS referral resources. You may even be asked sophisticated medical questions to which individuals have not obtained satisfactory answers from their own health care providers.

<u>How to deal with religion, values, morality, etc.</u> "A tisket, a tasket, a condom or a casket." The first time I heard this rhyme was from a nun teaching in a Catholic boys' high school. I believe that it is impossible to make a course on HIV disease value free, or value neutral if there even is such a concept. Therefore, in my syllabus and verbal introduction to the course I state that my foremost and ultimate goal is "to stop the spread of the human immunodeficiency virus/AIDS." I also state that I am willing to do this by any means virtually possible, even if that means there are possible violations of statute law involved (e.g., needle exchange). It is the means, not the ends, over which conflict often arises. Posing a decision making tree, or hierarchy of values and priorities, sometimes helps to illustrate these issues (e.g., differentiating between the quality vs. quantity of life remaining for a terminally ill patient), but this is not an easy issue to address, and I do not have any magic solutions for dealing with value conflict dilemmas. The same dilemma applies to the type of language used in the classroom. You cannot always use "correct, medical terminology," nor should you, and neither can or will your students, guest lecturers, the course readings, etc. <u>You will</u> (dare I say should?) <u>offend some, there is no way to avoid this.</u> Hopefully they will remain in the class, and also not

create problems with external "authorities" on and off campus. People use these terms in real life, they may well know no others, and you have to know/use their language to communicate with them. You might try to anticipate how your campus hierarchy would respond to complaints if they do arise.

The same value dilemma applies to teaching students from diverse cultures and subcultures. Many of us are from areas with high proportions of Puerto Rican and Hispanic Catholics, Asians, and other groups which are neither similar nor homogeneous in their values and beliefs. The values, attitudes, operating rules, and meanings attached to sexuality, bi and homosexuality, disease, birth control, drug usage, the family, the patriarchy and matriarchy, etc. all vary tremendously both among and within these cultures. To the extent that your students are culturally diverse, your teaching must be too, and you may well need help in making it so. As an example: My homophobic basketball players, especially the black ones, could not see the threat of HIV to their own culture They argued for such extremes as quarantine of HIV+ individuals, yet one of them wrote in an exam that his own mother had died of AIDS.

Dealing with "current events," the promised cure, etc. You will frequently be asked to comment on some new development, a vaccine, an antiviral, etc., that has been reported in the popular press, possibly asked even before you have heard the "news". I see two issues here: 1) the negative of not letting this take too much time away from your planned coverage for the day, and 2) the positive of using it to teach the canons of scientific research and scientific reporting vs. what is said in and how to read the popular press. Teach your students how to read the bottom line, the caveats, etc. The best way around this type of question, if you are unprepared, is to postpone it until the next class so that you have had a chance to study the issue firsthand and at your leisure.

This brings up a pedagogical device which I have often used. This is at the first class meeting, and periodically during the semester, to have students write their questions, concerns, etc., anonymously on a 3 x 5 file card which is handed in at the end of class. Then, with preparation, you can address the question asked at a later class period. This device has several advantages: especially initially, it allows you to learn of students' common concerns, it avoids the risk of giving incomplete or incorrect off the cuff answers; it allows you to develop your answer more carefully. It also gives you time to consult with "expert sources," if need be. The problem with this method is the questions asked in writing may be vague or incomplete, where a proper answer requires more information on what is

really being asked. Your source is, and may desire to remain, anonymous; thus you cannot properly address the question which is really being asked.

Resolving conflict among sources of information: students, and many others, have a low tolerance for ambiguity and conflict among sources of information, yet this is a frequent state of affairs in information relating to HIV. Sometimes it is only the more knowledgeable and sophisticated students who voice their concerns over the inconsistency, but that can be even worse; the others may be confused too, but do not know how to voice their confusion. This conflict occurs because knowledge is not absolute; parts of sources which you use (e.g., texts) may be dated, even ever so slightly (although the rest of the source may be superb); or the information given is too general, or not qualified as it should be. It is easy to overlook these problems; on the other hand, spending too much time on them can confuse and complicate things for much of your audience. What do you do? Try to teach tolerance of ambiguity; let people learn that science and medicine are far from absolute, but instead are very relative and probabilistic; that they are ever changing; that medicine is as much, if not more, an art as it is a science. There will be some who you will never satisfy, they want absolute assurances and answers; at least you tried.

Finding an appropriate level of knowledge and sophistication at which to teach the course. This can be difficult, and I cannot give you a satisfactory answer to the issue here (I am not sure that I have one for myself). During the first class meeting I get some written background data from the students enrolled, including their previous relevant courses, knowledge, and experience - personal, family, volunteer, professional/work related, etc. During the first class I have also used an anonymous survey instrument to ascertain students' demographics, sexual and drug use history, knowledge (and lack thereof; myths and fallacies), and values and phobias concerning homosexuality, AIDS, drug usage, etc. Although I am not convinced this is worth the time and effort involved for me, I think that in geographic areas of lower HIV prevalence and knowledge it can be of greater utility. While these techniques do not help in text and reading selection, which has already taken place, they can let you know how much basic biology, human sexuality, etc., you will need to cover in lectures. They can also help in deciding to add "remedial" reading if appropriate. The techniques also make you aware of resource individuals in the class upon whom you can draw. My practicing nurses have helped to answer not a few in class questions for which I was not totally prepared.

As with many college courses, people enroll for a vast variety of reasons ranging from time of day the course meets to their own personal

needs and/or agendas. From these information cards you may learn about some red flags, such as religious or pro/anti abortion activism by students; knowing this you might choose to discuss or present some course materials differently, or at least be prepared for vehement and vocal opposition to some of your viewpoints.

If I do not know it already (from my community volunteer work), sometimes individuals volunteer their own gay/lesbian sexual orientation and HIV+ status on their information cards. I think that every semester I have had as enrollees gay males, lesbians, HIV+ individuals, and family members (certainly friends) of all of these groups. Of course their level of course participation, actual knowledge and level of understanding of HIV, and degree of openness about these personal characteristics, varies tremendously.

Course topical coverage: In this respect I think my course differs somewhat from Dr. Heyman's. While we cover many of the same topics, at least in the readings I place more emphasis on public policy issues, and less on psychosocial ones. This is more a result of my own personal interests, and the anarchic freedom allowed by my Department, than a denial of the importance of psychosocial factors in AIDS. Additionally, there is so much that one could cover, that content selection is quite arbitrary and I have added and deleted various topics over the semesters. Even if the course texts have a good glossary, it may help to provide another one. Every semester I provide an updated epidemiology statistics handout, including data from the international level down to as local a level as practicable while still keeping high validity. The CDC epidemiology slides are good to lecture from, their pie charts are especially impacting, but their numbers are always out of date (I make sure to stress that the percentages on the slides should not change too rapidly over time, but the absolute values are ever increasing).

The balance among and useful pedagogical devices: that is, your own lectures, guest lectures, media presentations, and experiential exercises. Guest lecturers: (1) Each semester I have consistently invited guest lecturers on safe sex techniques (the Sacramento AIDS Foundation has a wonderful team of presenters), this helps to distance you from the nitty gritty of prevention, and I think that it allows for more open questions from some students (they might not want to ask their course professor about the advisability of personal behaviors, and I do not necessarily stay in the room for the whole presentation). Also, maybe these outside presenters are a bit more "creditable" for these topics. A male/female pair is always good to do this. (2) I ask a drug abuse counselor to present, and as she often does teen and school based educational presentations, she also gives the audience

a good perspective on that aspect of AIDS work. (3) I usually have someone speak on the diverse issues involving women and AIDS. The majority of the class has been female. They cover such topics as risk behaviors and partners at risk; specialized female medical issues as discrimination, and the lack of access to care; empowerment and safer sex negotiation; childbearing and families; etc. (4) The health educator from our County AIDS unit often speaks, sometimes in conjunction with someone from the Hemophilia Society. (5) One of the therapeutic drug researchers from our local medical school presents on the issues of the FDA, drug trials, compassionate use, and drug research development and protocols. (6) During other semesters I have had staff persons from the California State Legislature and U.S. Congress (Steve Morin); a physician who runs the local medical center AIDS clinic; a health educator from a teen clinic; our own campus AIDS health educator or her student interns. (7) Once I paired a newspaper and a TV reporter, both of whom cover medical and AIDS issues, discussing the media's role in presenting science and medical news. Interestingly, they knew of each other, but had never met in person. We even put class on the local 5:00 PM TV news. (8) Of course I have a panel of two or three PWAs; one is really not enough, too many could be unwieldy. Two or three persons can give a balanced viewpoint; it is even better if their lifestyles, economic status, transmission modes, etc., are different - contrast is a real educator. If possible, represent both sexes. Your own resource pool will, obviously, affect your choice of guests. And not everyone is going to have these resource persons available. Some may have more; most will probably have even fewer. A course like Dick Siegel had at UCLA, or the one currently taught at Stanford, is my envy - when you want to discuss drug trials, you get Jere Goyan, former FDA Commissioner, down from UCSF. But my dear friend Al Novick of Yale's biology department does a superb job with a minimum of guest lecturers and an enrollment of 400+ per semester!

How much and what audiovisual material should you use?
Slides are fairly limited, and the CDC epidemiology sets are generally about all the slides I have used. Most of those available from drug companies and medical sources are too sophisticated and technical. If your campus can make slides from books and periodicals, you can have some good ones made up. The National Geographic's "Cell Wars" issue on the immune system (June 1986) contains some good materials. While complex, I photocopied the two page diagrammatic representation and narrative of the immune system's composition and functioning into a reference handout, and also use it as a slide from which I lectured.
Videotapes and films: Here, in addition to how many to use, the problem is what to select; there is too much out there (especially in the area of AIDS/HIV transmission prevention), and not all of it is either good or

appropriate for the college level. The length of each class period is one deciding factor, e.g., how do you squeeze a one hour AIDS Quarterly into a fifty minute class? I have not suggested or required outside viewing of lengthy media material by the students, which may be one option. What do I use? Sometimes bits and pieces of news programs that I have edited down myself; an occasional AIDS Quarterly; Common Threads (stories from The Quilt, its uncut time, with credits, is 1 HR 19 m); a collection of other materials that I have built up over the years. I use a PBS Frontline program entitled "Who pays for AIDS" to cover health care economics from both an individual and societal level, and an AIDS Quarterly entitled "Other faces of AIDS" for a look at the minority (largely Black) community's response to the epidemic. I think that neither of these are dated, and they should be available from PBS. Of course new programs appear quite regularly, and must be prepared to watch all too many of them in order to select the appropriate ones.

Finally, a word on experiential exercises: I usually use three of these. As I have copies of two of them for distribution, I shall only describe them here. One is called "The transmission game;" it shows the rapid spread of HIV within a closed community (your classroom). It is very dramatic and effective. Another is called "The Giving Away" exercise, and it demonstrates on a very personal level how much persons living with HIV disease (or any other life limiting or threatening condition for that matter) must discard and give up during the process of dying/on the road to death. Lastly, when I discuss biomedical ethics and medical decision making, I have small groups role play a series of decision making dilemmas which involve conflicting options for the treatment of patients, the "rights" of the patient vs. others in making treatment decisions, and problems of decision making under conditions of limited/scarce resources. The exercise is borrowed from chapter 3 of Comfort in caring - nursing the person with HIV infection by Janice Bell Meisenhelder and Christopher LaCharite (Scott Foresman/Little Brown, 1989); since it is copyrighted, I cannot reproduce it for distribution to you. When it is finalized, the stages in the development of Oregon's plan for rationing medical treatment might work well work here.

The distribution of activities across class periods: Out of thirty seventy-five minute classes in a semester, I have often divided them up as follows: two mid-terms and a final exam for a total of three classes; six classes with guest lecturers; twelve classes with my own lectures and general discussions, which also fill in gaps; six media presentation classes either with or without time during that class for discussion; three classes with experiential exercises.

AIDS burnout: This may affect only a few of you. I think I am an AIDS junkie. I have been deeply involved in the field since 1983, and well recall when the first reports of KS and PCP came out in MMWR. At that time I was teaching both human sexuality and death and dying, thus read MMWR for the STD statistics as well as other items. I can't seem to escape the epidemic, and keep on going back for more - getting involved in different ways. But there is an underlying depression that can be difficult to cope with as a result of so many cumulative losses and deaths: my own partner, friends, colleagues, "clients", buddies, students, (no family or relatives that I know of yet), not to mention the loss to humanity. Sabbaticals are needed; I vary my AIDS activities, for example, decrease direct buddy services and increase political lobbying; do not teach this course every semester - I am actually skipping it for a whole year (partly because of a sabbatical), etc.

In conclusion, I have covered quite a bit of material. Hopefully some of the information given will be useful to you. I look forward to the time when there will no longer be a need for courses on HIV disease/AIDS, then we can fight the next battle - whatever it may be.